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ABSTRACT

Although suicide is the second leading cause of death for adolescents in the United States, there are little empirical data available on psychological factors which may lead an adolescent to consider or attempt suicide. To address this issue, the relationships among depression, social skills, and severity of suicidal attempt were investigated in 30 adolescents who were admitted to a general hospital following a suicide gesture or attempt. Subjects were classified into high (N=16) or low (N=14) risk attempters based on their history of previous attempts, lethality of attempt, and disposition (inpatient versus outpatient treatment). Subjects completed the Children's Depression Inventory (CDI), Hopelessness Scale for Children, and the Matson Evaluation of Social Skills with Youngsters. Data analysis revealed no differences between the high risk and the low risk suicide attempters on any of the self-report measures used. Nonetheless, the results suggest that overall levels of psychological distress as reflected by the Hopelessness Scale and the CDI may contribute to suicide attempts since the mean scores obtained in this study were much higher than those reported in studies with normal children and with a mixed group of child psychiatric patients. In addition, the negative relationship between depression and appropriate social skills which is seen in normal populations was not found in this group of adolescent suicide attempters. (NB)

The Relationship Between Social Skills and Depression in Adolescent Suicide Attempters

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INTRODUCTION

Suicide is the second leading cause of death for adolescents in the United States. However, little empirical data is available regarding psychological factors which may lead an adolescent to consider--or attempt--suicide. Certainly, suicidal behavior is multi-determined and based on a diversity of precipitating factors. For example, the relationship among hopelessness, depression, and suicidal intent has been the focus of study in both adults (Wetzel, Margulies, Davis, & Karam, 1980) and children (Kazdin, French, Unis, Esveldt-Dawson, & Sherick, 1983). Similarly, social skill level and socialization factors have been implicated in level of depression in children (Strauss, Forehand, Frame & Smith, 1984). Accordingly, the role of social skills deficits in adolescent suicidal behavior is of theoretical and clinical interest. Indeed, clinical experience with this population suggests that certain adolescent suicide attempters have difficulty in effectively impacting their environment, obtaining desirable outcomes, avoiding undesirable outcomes, and interacting within a supportive social network. The aim of the present investigation was to examine the relationship among depression, social skills, and severity of suicidal attempt in a population of adolescents who were admitted to a general hospital following a suicide gesture or attempt.

METHOD

Thirty adolescents hospitalized on a general pediatrics floor following a suicide attempt formed the study population. They ranged in age from 12 to 17 years. Subjects were broken down into two groups based on the severity of the suicide attempt. Subjects were classified into high or low risk attempters according to the following criteria: (1) History of previous attempts, (2) Lethality of attempt, and (3) Disposition--inpatient versus outpatient treatment. The low risk group consisted of 14 adolescents, 10 females and 4 males while 16 adolescents, 11 females and 5 males, comprised the high risk group. There was no difference between the two groups in age. Each subject was individually administered the Children's Depression Inventory (CDI)[3] Hopelessness Scale for Children[2], and the Matson Evaluation of Social Skills with Youngsters (MESSY)[5] within two to three days after admission to the hospital.

RESULTS

Data analysis indicated that there were no differences between the high risk and the low risk suicide attempters on any of the self-report measures used (See Table 1).

Additional analyses were performed in order to examine any differences between high (CDI>27) and low (CDI<14) scorers on the CDI in this group of suicide attempters. Analysis of variance did reveal several differences as reflected in Table 2. Specifically, adolescent suicide attempters with high CDI scores had significantly higher scores on The Hopelessness Scale ($p<.001$) and MESSY Factors II (Inappropriate Assertiveness, $p<.05$), III (Impulsive/Recalcitrant Behavior, $p<.05$), and V (Overconfidence, $p<.01$).

	Lo Risk Suicide Attempters (N=14)		Hi Risk Suicide Attempters (N=16)		
	Mean	S.D.	Mean	S.D.	P
Age in years	15.0	1.8	15.6	1.4	NS
CDI	19.0	13.2	20.3	12.3	NS
Hopelessness Scale	5.7	4.7	7.2	4.5	NS
MESSY I	82.0	18.2	88.0	10.5	NS
II	32.9	10.0	3C.1	5.8	NS
III	12.8	4.4	11.4	2.1	NS
IV	8.1	1.9	8.2	2.3	NS
V	9.9	3.7	9.6	3.0	NS

Table 1. Comparison of Hi and Lo Risk Adolescent Suicide Attempters on Age, Children's Depression Inventory (CDI), Hopelessness Scale for Children, and Matson Evaluation of Social Skills for Youngsters (MESSY).
(MESSY FACTORS: I: Appropriate Social Skills, II: Inappropriate Assertiveness, III: Impulsive/Recalcitrant Behavior, IV: Jealousy/Withdrawal, V: Overconfidence)

	Lo Scorers on CDI (N=9)		Hi Scorers on CDI (N=10)		
	Mean	S.D.	Mean	S.D.	P
Age in years	15.8	1.3	15.0	1.8	NS
Hopelessness Scale	2.7	2.4	10.9	4.3	.001
Messy I	90.1	8.8	81.8	18.3	NS
II	27.1	3.9	36.4	9.4	.05
III	10.3	2.7	14.3	3.7	.05
IV	7.7	1.7	8.2	2.0	NS
V	7.4	2.3	11.8	2.9	.01

Table 2. Comparison of Hi and Lo CDI Scorers on Age, Hopelessness Scale, and MESSY. (MESSY FACTORS: I: Appropriate Social Skills, II: Inappropriate Assertiveness, III: Impulsive/Recalcitrant Behavior, IV: Jealousy/Withdrawal, V. Overconfidence).

	CDI	H	I	II	III	IV
H	.72+					
I	-.17	-.37				
II	.77+	.57	-.36			
III	.59*	.28	-.11	.75+		
IV	.42	.53	-.52*	.50	.23	
V	.75+	.59	-.21	.79+	.74+	.35

Table 3. Correlation MATRIX for the Lo Risk Adolescent Suicide Attempters (N=14). CDI = Children's Depression Inventory, H = Hopelessness Scale, I, II, III, IV, V = MESSY Factors

+p<.001
**p<.01
*p<.05

	CDI	H	I	II	III	IV
H	.85+					
I	-.24	-.25				
II	.01	-.06	.16			
III	.09	.18	.30	.31		
IV	-.15	-.19	.17	-.01	-.11	
V	.29	.17	.53*	.42	.18	.49*

Table 4. Correlation Matrix for the High Risk Adolescent Suicide Attempters (N=16). CDI = Children's Depression Inventory; H = Hopelessness Scale; MESSY Factors = I, II, III, IV, V.

+p<.0001

*p<.05

DISCUSSION

The lack of difference between severe and mild suicide attempters on various self-report measures was somewhat surprising. It was hypothesized that those adolescents who made severe suicide attempts would report higher levels of depression and hopelessness and more social skills deficits. The small sample size and the substantial variability in scores certainly may have affected the ability to detect statistical differences. Nonetheless, the results suggest that overall level of psychological distress--as reflected by the Hopelessness Scale for Children and the Children's Depression Inventory may indeed contribute to an eventual suicide attempt since the mean scores obtained on these measures for this sample were much higher than those reported in studies with normals (e.g., 1, 8) and studies with a mixed group of child psychiatric inpatients (e.g., 2, 7) and outpatients (e.g., 4). More specific constructs, such as hopelessness, did not prove helpful in discriminating severity of attempt, however.

A previous study (2) with a somewhat younger population was also unable to detect any differences between suicide attempters and ideators. The results would suggest that although hopelessness is strongly related to suicide, other factors are needed to predict ideators from mild attempters and severe attempters. The findings of this study also suggest that dispositions based on limited data, such as severity of attempt, may be erroneous, and other factors need to be considered closely. For example, when the group was divided into the ten highest scorers on the CDI (M=34.5, S.D.=15.6), five adolescents had made a severe attempt and five had made a mild attempt. Similarly, of the nine lowest scorers on the CDI (M=5.77, S.D.=3.97), had made mild attempts and four had made severe attempts.

Another possible explanation for the failure to detect differences between suicide attempters may be in the criteria used to discriminate groups. The subjects in the present study had initially been classified on commonly used measures of suicide risk-the Beck Suicide Intent Scale and Weismar's Risk-Rescue Rating Scale. However, using these rating scales, little variability was noted among the attempters, and they could not be meaningfully divided (e.g., 90% of our sample attempted suicide via drug ingestion) despite the fact that clinicians frequently render dispositions based on severity of the attempt. Consequently, groups were classified according to commonly used clinical and research (e.g., 6) criteria. A more precise classification system designed specifically for adolescents may, in fact, reveal differences on self-report measures.

Finally, our data regarding the relationship between social skills and depression was mixed. In general, the correlations between social skills and depression were rather modest, and indeed, there were no differences noted as a function of severity of attempt. There were differences on assertiveness, impulsivity, and overconfidence between the high and low scorers on the CDI but non on appropriate social behavior. Thus, the negative relationship between depression and appropriate skills which is seen in normal populations (e.g. 1) was not found in this group of adolescent suicide attempters. Teacher ratings formed the basis of the findings of the previously cited study, whereas the present study employed self-report measures, and this difference in method may be the primary reason for the discrepancy. The use of a single assessment method--self-report--is a weakness of the present study, but reflects the reality of clinical work in our setting. The disparity of findings may also reflect differences between clinical and normal groups. Future research should continue to explore hypothesized relationships among constructs such as depression, hopelessness and social behavior as they apply across different clinical and normal populations.

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